I

103D CONGRESS
2D SESSION

H. R. 4519

To increase access to health insurance for employees of small businesses, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 26, 1994

Mr. MANZULLO introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Education and Labor, Ways and Means, and the Judiciary

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A BILL

To increase access to health insurance for employees of small businesses, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the ''Small Business Health Insurance Choice Act''.

(b) FINDINGS RELATING TO INTERSTATE COMMERCE.—Congress finds that health insurance is a critical part of the economy of the United States and interstate commerce, consumes a significant percentage of public

and private spending, and affects all industries and individuals in the United States.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—IMPROVED ACCESS TO AFFORDABLE HEALTH CARE

Subtitle A—Increased Availability and Continuity of Health Coverage for Employees and Their Families

PART 1—PREEXISTING CONDITIONS AND CONTINUITY OF COVERAGE; RENEWABILITY

SEC. 101. LIMITATION ON PRE-EXISTING CONDITION CLAUSES.

A group health plan may not impose (and an insurer may not require an employer under a group health plan to impose through a waiting period for coverage under a plan or similar requirement) a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition pre-existed the effective date of the plan with respect to an individual if—

(1) the condition relates to a condition that was not diagnosed or treated within 3 months before the date of coverage under the plan;

(2) the limitation or exclusion extends over more than 6 months after the date of coverage under the plan;

(3) the limitation or exclusion applies to an individual who, as of the date of birth, was covered under the plan; or

(4) the limitation or exclusion relates to pregnancy.

In the case of an individual who is eligible for coverage under a plan but for a waiting period imposed by the employer, in applying paragraphs (1) and (2), the individual shall be treated as having been covered under the plan as of the earliest date of the beginning of the waiting period.

SEC. 102. ASSURANCE OF CONTINUITY OF COVERAGE THROUGH PREVIOUS SATISFACTION OF PREEXISTING CONDITION REQUIREMENT.

(a) IN GENERAL.—Each group health plan shall waive any period applicable to a preexisting condition for similar benefits with respect to an individual to the extent that the individual, prior to the date of such individual's enrollment in such plan, was covered for the condition under any other health plan that was in effect before such date.

(b) CONTINUOUS COVERAGE REQUIRED.—

(1) IN GENERAL.—Subsection (a) shall no longer apply if there is a continuous period of more than 60 days (or, in the case of an individual de-

scribed in paragraph (3), 6 months) on which the individual was not covered under a group health plan.

(2) TREATMENT OF WAITING PERIODS.—In applying paragraph (1), any waiting period imposed by an employer before an employee is eligible to be covered under a plan shall be treated as a period in which the employee was covered under a group health plan.

(3) JOB TERMINATION.—An individual is described in this paragraph if the individual loses coverage under a group health plan due to termination of employment.

(4) EXCLUSION OF CASH-ONLY AND DREAD DISEASE PLANS.—In this subsection, the term ''group health plan'' does not include any group health plan which is offered primarily to provide—

(A) coverage for a specified disease or illness, or

(B) a hospital or fixed indemnity policy, unless the Secretary determines that such a plan provides sufficiently comprehensive coverage of a benefit so that it should be treated as a group health plan under this subsection.

SEC. 103. REQUIREMENTS RELATING TO RENEWABILITY GENERALLY.

(a) MULTIEMPLOYER PLANS AND EXEMPTED MULTIPLE EMPLOYER HEALTH PLANS.—A multiemployer plan and an exempted multiple employer health plan may not cancel coverage or deny renewal of coverage under such a plan with respect to an employer other than—

(1) for nonpayment of contributions,

(2) for fraud or other misrepresentation by the employer,

(3) for noncompliance with plan provisions,

(4) for misuse of a provider network provision, or

(5) because the plan is ceasing to provide any coverage in a geographic area.

(b) INSURERS.—

(1) IN GENERAL.—An insurer may not cancel a health insurance plan or deny renewal of coverage under such a plan other than—

(A) for nonpayment of premiums,

(B) for fraud or other misrepresentation by the insured,

(C) for noncompliance with plan provisions,

(D) for misuse of a provider network provision, or

(E) because the insurer is ceasing to provide any health insurance plan in a State, or, in the case of a health maintenance organization, in a geographic area.

(2) LIMITATION ON MARKET REENTRY.—If an insurer terminates the offering of health insurance plans in an area, the insurer may not offer such a health insurance plan to any employer in the area until 5 years after the date of the termination.

PART 2—ENFORCEMENT; EFFECTIVE DATES; DEFINITIONS

SEC. 111. ENFORCEMENT.

(a) ENFORCEMENT BY DEPARTMENT OF LABOR FOR EMPLOYERS AND GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of part 1 of this subtitle shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor under this subtitle pursuant to subsection (a), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

(b) ENFORCEMENT BY EXCISE TAX FOR INSURERS.—

(1) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end thereof the following new section:

"SEC. 4980C. FAILURE OF INSURER TO COMPLY WITH HEALTH INSURANCE STANDARDS.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of an insurer to comply with the requirements applicable to the insurer under part 1 of subtitle A of title I of the Small Business Health Insurance Choice Act.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by an insurer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an insurer.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each individual to which such failure re-

lates. A rule similar to the rule of section 4980B(b)(3) shall apply for purposes of this section.

''(2) LIMITATION.—The amount of the tax imposed by subsection (a) for an insurer with respect to a health insurance plan shall not exceed 25 percent of the amounts received under the plan for coverage during the period such failure persists.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the insurer.

''(d) EXCEPTIONS.—

''(1) CORRECTIONS WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) by reason of any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected within the 30-day period beginning on earliest date the insurer knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of such tax would be excessive relative to the failure involved.

''(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance plan' and 'insurer' have the respective meanings given such terms in section 113 of the Small Business Health Insurance Choice Act.''

(2) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end thereof the following new items:

''Sec. 4980C. Failure of insurer to comply with health insurance standards.''

SEC. 112. EFFECTIVE DATES.

(a) PART 1.—The requirements of part 1 with respect to—

(1) group health plans and employers shall apply to plans years beginning after December 31, 1994, and

(2) insurers shall take effect on January 1, 1995.

SEC. 113. DEFINITIONS.

(a) IN GENERAL.—For purposes of this subtitle:

(1) EMPLOYER.—The term ''employer'' shall have the meaning applicable under section 3(5) of the Employee Retirement Income Security Act of 1974.

(2) EXEMPTED MULTIPLE EMPLOYER HEALTH PLAN.—The term ''exempted multiple employer health plan'' means a multiple employer welfare ar-

rangement treated as an employee welfare benefit plan by reason of an exemption under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by part 2 of subtitle C of this title).

(3) GROUP HEALTH PLAN; PLAN.—(A) The term ''group health plan'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of a health insurance plan under section 1107(4)(B).

(B) The term ''plan'' means, unless used with a modifying term or the context specifically indicates otherwise, a group health plan (including any such plan which is a multiemployer plan), an exempted multiple employer health plan, or an insured multiple employer health plan.

(4) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service

plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(5) INSURED MULTIPLE EMPLOYER HEALTH PLAN.—The term ''insured multiple employer health plan'' means a fully insured multiple employer welfare arrangement under which benefits consist solely of medical care described in section 607(1) of the Employee Retirement Income Security Act of 1974 (disregarding such incidental benefits as the Secretary of Health and Human Services shall specify by regulations).

(6) INSURER.—The term ''insurer'' means a licensed insurance company, a prepaid hospital or medical service plan, and a health maintenance organization offering such a plan to an employer, and includes a similar organization regulated under State law for solvency.

(7) STATE.—The term ''State'' means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Subtitle B—Preemption of Scope of State Regulation

SEC. 121. PROHIBITION OF STATE BENEFIT MANDATES FOR GROUP HEALTH PLANS.

In the case of a group health plan, no provision of State or local law shall apply that requires the coverage of one or more specific benefits, services, or categories of health care, or services of any class or type of provider of health care.

SEC. 122. PROHIBITION OF PROVISIONS PROHIBITING EMPLOYER GROUPS FROM PURCHASING HEALTH INSURANCE.

No provision of State or local law shall apply that prohibits 2 or more employers from obtaining coverage under an insured multiple employer health plan.

SEC. 123. RESTRICTIONS ON MANAGED CARE.

(a) PREEMPTION OF STATE LAW PROVISIONS.—Subject to subsection (c), the following provisions of State law are preempted and may not be enforced:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan to negotiate reimbursement rates with providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that a group health plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General shall conduct a study of the benefits and cost effectiveness of the use of managed care in the delivery of health services.

(2) REPORT.—By not later than 4 years after the date of the enactment of this Act, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) and shall include in the report such recommendations (including

whether the provisions of subsection (a) should be extended) as may be appropriate.

(c) SUNSET.—Unless otherwise provided, subsection (a) shall not apply 5 years after the date of the enactment of this Act.

SEC. 124. DEFINITIONS.

For purposes of this subtitle, the terms ''employee'', ''employer'', ''group health plan'', ''health insurance plan'', ''insured multiple employer health plan'', and ''State'' have the meanings given such terms in section 113.

Subtitle C—Health Deduction Fairness

SEC. 131. PERMANENT EXTENSION AND INCREASE IN HEALTH INSURANCE TAX DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS.

(a) PERMANENT EXTENSION OF DEDUCTION.—

(1) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking paragraph (6).

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 1994.

(b) INCREASE IN AMOUNT OF DEDUCTION.—

(1) IN GENERAL.—Paragraph (1) of section 162(l) of such Code is amended by striking ''25 percent of'' and inserting ''100 percent (50 percent in the case of taxable years beginning in 1996 or 1997) of''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1994.

SEC. 132. DEDUCTION OF HEALTH INSURANCE PREMIUMS FOR CERTAIN PREVIOUSLY UNINSURED INDIVIDUALS.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

''(f) DEDUCTION FOR HEALTH INSURANCE COSTS DETERMINED WITHOUT REGARD TO ADJUSTED GROSS INCOME THRESHOLD.—

''(1) IN GENERAL.—Subsection (a) shall be applied without regard to the limitation based on adjusted gross income in the case of the applicable percentage of the amounts paid for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means—

''(A) 25 percent for taxable years beginning in 1995 or 1996,

''(B) 50 percent for taxable years beginning in 1997 or 1998, and

''(C) 100 percent for taxable years beginning after 1999.

''(3) DEDUCTION NOT ALLOWED TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any individual—

''(i) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

''(ii) who is (or whose spouse is) a member of a subsidized class of employees of an employer.

''(B) SUBSIDIZED CLASS.—For purposes of subparagraph (A), an individual is a member of a subsidized class of employees of an employer if, at any time during the 3 calendar years end-

ing with or within the taxable year, any member of such class was eligible to participate in any subsidized health plan maintained by such employer.

''(C) SPECIAL RULES.—

''(i) CONTROLLED GROUPS.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as a single employer for purposes of subparagraph (B).

''(ii) CLASSES.—Classes of employees shall be determined under regulations prescribed by the Secretary based on such factors as the Secretary determines appropriate to carry out the purposes of this subsection.

''(4) COORDINATION WITH DEDUCTION FOR OTHER AMOUNTS.—Amounts allowable as a deduction under subsection (a) by reason of this subsection shall not be taken into account in determining the deduction under subsection (a) for other amounts.

''(5) SUBSECTION NOT TO APPLY TO INDIVIDUALS ELIGIBLE FOR MEDICARE.—This subsection

shall not apply to amount paid for insurance covering an individual who is eligible for benefits under title XVIII of the Social Security Act.''

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (15) the following new paragraph:

''(16) COSTS OF CERTAIN HEALTH INSURANCE.—The deduction allowed by section 213 to the extent allowable by reason of section 213(f).''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

TITLE II—REMOVING ANTITRUST IMPEDIMENTS

SEC. 201. ESTABLISHMENT OF LIMITED EXEMPTION PROGRAM FOR HEALTH CARE JOINT VENTURES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Attorney General, after consultation with the Secretary of Health and Human Services and the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care, shall promulgate specific guidelines under which a health care joint venture

may submit an application requesting that the Attorney General provide the entities participating in the joint venture with an exemption under which (notwithstanding any other provision of law)—

(A) monetary recovery on a claim under the antitrust laws shall be limited to actual damages if the claim results from conduct within the scope of the joint venture that occurs while the exemption is in effect; and

(B) the conduct of the entity in making or performing a contract to carry out the joint venture shall not be deemed illegal per se under the antitrust laws but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including (but not limited to) effects on competition in properly defined, relevant research, development, product, process, and service markets (taking into consideration worldwide capacity to the extent that it may be appropriate in the circumstances).

(2) DEADLINE FOR RESPONSE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall approve or disapprove the application of a health care joint venture for an

exemption under this subsection not later than 30 days after the Attorney General receives the joint venture's application.

(3) PROVIDING REASONS FOR DISAPPROVAL.—If the Attorney General disapproves the application of a health care joint venture for an exemption under this subsection, the Attorney General shall provide the joint venture with a statement explaining the reasons for the Attorney General's disapproval.

(b) REQUIREMENTS FOR APPROVAL.—For purposes of subsection (a), the Attorney General shall approve the application of a health care joint venture for an exemption under subsection (a) if an entity participating in the joint venture submits to the Attorney General an application not later than 30 days after the entity has entered into a written agreement to participate in the joint venture (or not later than 30 days after the date of the enactment of this Act in the case of a joint venture in effect as of such date) that contains the following information and assurances:

(1) The identities of the parties to the joint venture.

(2) The nature, objectives, and planned activities of the joint venture.

(3) Assurances that the entities participating in the joint venture shall notify the Attorney General of any changes in the information described in paragraphs (1) and (2) during the period for which the exemption is in effect.

(c) REVOCATION OF EXEMPTION.—

(1) IN GENERAL.—The Attorney General, after consultation with the Secretary, may revoke an exemption provided to a health care joint venture under this section if, at any time during which the exemption is in effect, the Attorney General finds that the joint venture no longer meets the applicable requirements for approval under subsection (b), except that the Attorney General may not revoke such an exemption if the failure of the health care joint venture to meet such requirements is merely technical in nature.

(2) TIMING.—The revocation of an exemption under paragraph (1) shall apply only to conduct of the health care joint venture occurring after the exemption is no longer in effect.

(d) WITHDRAWAL OF APPLICATION.—Any party that submits an application under this section may withdraw such application at any time before the Attorney General's response to the application.

(e) REQUIREMENTS RELATING TO NOTICE AND PUBLICATION OF EXEMPTIONS AND RELATED INFORMATION.—

(1) PUBLICATION OF APPROVED APPLICATIONS FOR EXEMPTIONS IN FEDERAL REGISTER.—

(A) IN GENERAL.—With respect to each exemption for a health care joint venture provided under subsection (a), the Attorney General (acting jointly with the Secretary) shall—

(i) prepare a notice with respect to the joint venture that identifies the parties to the venture and that describes the planned activities of the venture;

(ii) submit the notice to the entities participating in the joint venture; and

(iii) after submitting the notice to such entities (but not later than 30 days after approving the application for the exemption for the joint venture), publish the notice in the Federal Register.

(B) EFFECT OF PUBLICATION.—An exemption provided by the Attorney General under subsection (a) shall take effect as of the date of the publication in the Federal Register

of the notice with respect to the exemption pursuant to subparagraph (A).

(2) WAIVER OF DISCLOSURE REQUIREMENTS FOR INFORMATION RELATING TO APPLICATIONS FOR EXEMPTIONS.—

(A) IN GENERAL.—All information and documentary material submitted as part of an application of a health care joint venture for an exemption under subsection (a), together with any other information obtained by the Attorney General, the Secretary, or the Advisory Committee in the course of any investigation, administrative proceeding, or case with respect to a potential violation of the antitrust laws by the joint venture with respect to which the exemption applies, shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies, except as relevant to a law enforcement investigation or in a judicial or administrative proceeding in which such information and material is subject to any protective order.

(B) EXCEPTION FOR INFORMATION INCLUDED IN FEDERAL REGISTER NOTICE.—Subparagraph (A) shall not apply with respect to information contained in a notice published in the Federal Register pursuant to paragraph (1).

(3) USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the fact of disclosure of conduct under an application for an exemption under subsection (a) and the fact of publication of a notice in the Federal Register under paragraph (1) shall be admissible into evidence in any judicial or administrative proceeding for the sole purpose of establishing that a person is entitled to the protections provided by an exemption granted under subsection (a).

(B) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for an exemption under subsection (a), or revokes an exemption under such section, neither the negative determination nor the statement of reasons therefore shall be admissible into evidence in any admin-

istrative or judicial proceeding for the purpose of supporting or answering any claim under the antitrust laws.

SEC. 202. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary and the Advisory Committee, shall issue in accordance with this section a certificate of public advantage to each eligible health care joint venture that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such venture, and the parties to such venture, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such venture if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care joint venture if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the venture outweigh the reduction in competition (if any) that is likely to result from the venture, and

(B) such reduction in competition is reasonably necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the venture is likely —

(i) to maintain or to increase the quality of health care,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care joint venture and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care joint venture on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the venture.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly

by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care joint venture (in the case of a venture in existence as of the time of the application) and implementation plan for the joint venture.

(d) ELIGIBLE HEALTH CARE JOINT VENTURE.—To be an eligible health care joint venture for purposes of this section, a health care joint venture shall submit to the Attorney General an application that complies with the rules in effect under subsection (c) and that includes—

(1) an agreement by the parties to the venture that the venture will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the venture,

(2) an agreement that the venture will submit to the Attorney General annually a report that de-

scribes the operations of the venture and information regarding the impact of the venture on health care and on competition in health care, and

(3) an agreement that the parties to the venture will notify the Attorney General and the Secretary of the termination of the venture not later than 30 days after such termination occurs.

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 30 days after an eligible health care joint venture submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 30-day period, the Attorney General fails to issue or deny the issuance of such certificate, the Attorney General shall be deemed to have issued such certificate.

(f) REVOCATION OF CERTIFICATE.—Whenever the Attorney General finds that a health care joint venture with respect to which a certificate is in effect does not meet the standards specified in subsection (b), the Attorney General shall revoke such certificate.

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an applica-

tion for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney

General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care joint venture with respect to which such a certificate is in effect.

SEC. 203. INTERAGENCY ADVISORY COMMITTEE ON COMPETITION, ANTITRUST POLICY, AND HEALTH CARE.

(a) ESTABLISHMENT.—There is hereby established the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care. The Advisory Committee shall be composed of—

(1) the Secretary of Health and Human Services (or the designee of the Secretary);

(2) the Attorney General (or the designee of the Attorney General);

(3) the Director of the Office of Management and Budget (or the designee of the Director); and

(4) a representative of the Federal Trade Commission.

(b) DUTIES.—The duties of the Advisory Committee are—

(1) to discuss and evaluate competition and antitrust policy, and their implications with respect to the performance of health care markets;

(2) to analyze the effectiveness of health care joint ventures receiving exemptions under the program established under section 201(a) or certificates under section 202 in reducing the costs of and expanding access to the health care services that are the subject of such ventures; and

(3) to make such recommendations to Congress not later than 2 years after the date of the enactment of this Act (and at such subsequent periods as the Advisory Committee considers appropriate) regarding modifications to the program established under section 201(a) or to section 202 as the Advi-

sory Committee considers appropriate, including modifications relating to the costs to health care providers of obtaining an exemption for a joint venture under such program.

SEC. 204. DEFINITIONS.

For purposes of this title:

(1) The term ''Advisory Committee'' means the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care established under section 203.

(2) The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(3) The term ''certificate'' means a certificate of public advantage authorized to be issued under section 202(a).

(4) The term ''health care joint venture'' means an agreement (whether existing or proposed) between 2 or more providers of health care services

that is entered into solely for the purpose of sharing in the provision of health care services and that involves substantial integration or financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(5) The term ''health care services'' includes services related to the delivery or administration of health care services.

(6) The term ''liable'' means liable for any civil or criminal violation of the antitrust laws.

(7) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(8) The term ''Secretary'' means the Secretary of Health and Human Services.

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